DRAFT

DELAWARE HEALTH CARE COMMISSION
NOVEMBER 3, 2011
DELDOT ADMINISTRATION BUILDING
FARMINGTON/FELTON CONFERENCE ROOM
DOVER

DRAFT

MINUTES

Commission Members Present: Bettina Riveros, Chair; Theodore W. Becker, Jr.; Thomas J. Cook, Secretary of Finance; A. Richard Heffron; Rita Landgraf, Secretary, Delaware Health and Social Services; Kathleen S. Matt, PhD; and Dennis Rochford

Commission Members Absent:
Janice E. Nevin, MD; Karen Weldin Stewart, Insurance Commissioner, and Vivian Rapposelli, Secretary, Services for Children, Youth and Their Families

Staff Attending: Paula Roy, Executive Director; Marlyn Marvel, Community Relations Officer; Robin Lawrence; Executive Secretary and Linda G. Johnson, Administrative Specialist III

Action Items

CALL TO ORDER

The meeting was called to order at 9:05 a.m. by Bettina Riveros, Commission Chair.

MEETING MINUTES OF JUNE 2, 2011

After a motion by Rich Heffron and seconded by Ted Becker, the minutes of the October 6, 2011 meeting, was approved by a vote of the Commissioners.

Action
Commissioners approved the October 6, 2011 DHCC meeting minutes.

Reappointments

Dr. Janice Nevin, Dean Kathleen Matt and Ted Becker have been reappointed by Governor Jack Markell to serve another term as Commission members. Chair Bettina Riveros thanked them for their continued service to the Commission.

RESEARCH & POLICY DEVELOPMENT

United Way of Delaware - Overview of the '211' Initiative - Michelle Taylor, President and CEO

Michelle Taylor, President and CEO of the United Way of Delaware, gave a presentation on the '211' initiative.

A PowerPoint presentation entitled, '*Our Journey to Date*' outlining the United Way's 2015 goals will be made available on the DHCC website: http://dhss.delaware.gov/dhss/dhcc/presentations.html).

United Way of Delaware underwent a transformation six years ago by refocusing on three core areas: education, income and health - believing they are the building blocks to a better life. United Way recognizes that those issues are too large for any one organization and is working with other community agencies to bring about the desired change.

In June 2011, United Way merged with the Delaware HelpLine and is re-branding under Delaware '211' for the State. More than sixty percent of the 211 systems across the United States are managed by the United Way.

In June 2011, United Way merged with the Delaware HelpLine and are re-branding under Delaware '211' for the State.

Delaware 211 is in the process of becoming air certified. Last year there were that over 119,000 calls to 211 and this year the total is already at 120,000. The third quarter of 2011 has seen a six percent increase in call volume even with a zero marketing budget.

The majority of calls are regarding food, utilities, health care and shelter but at this time there is no way to confirm that callers are being helped. Within the current structure only about one percent of callers are contacted to ensure their needs were met. One requirement of the air certification will be for United Way to demonstrate that there is a process in place to show that nearly 100 percent of phone calls were connected to service resources. If a caller's needs still were not met after exhausting the list of resources, 211 operators will be required to document that a caller had an unmet need and steps will be taken to resolve the lack of available services. Another requirement of certification is to articulate the need based upon the individuals that are reached and/or the unmet need. Data on unmet needs will be brought back to the appropriate organizations or legislators to talk about how United Way is working to meet those unmet needs. The third component of air certification is to work in the community

One of the key things happening is that Delaware 211 in the process of becoming air certified.

The majority of calls are regarding food, utilities, health care and shelter

Barbara Dibastiani asked Ms. Taylor if the outreach will be directed to organizations, small business or communities and to elaborate on how far that extends.

Ms. Taylor said her sense of outreach would be going where the need is - potentially having a resource person in a partner agency or a State Service Center once a month. Eight communities (four in New Castle County and two in each Kent and Sussex Counties) in Delaware have been identified as having the greatest poverty and will align its work to make sure there is outreach is in those communities.

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United Way launched 'Healthy Delawareans Today and Tomorrow' several years ago to do outreach to the uninsured in the State and be able to work more collaboratively. That group is evolving to ask how to know if its work is resulting in better outcomes and how to shift efforts from being acute to being more preventive and routine.

The second large project is working on an adolescent health initiative in partnership with the State, Astra Zeneca, Nemours, YMCA, and the Mental Health Association. The target age group is 12 to 15

years and focus will be on how to improve health outcomes that will also improve academic performance.

The second large project is working in partnership with the State, Astra Zeneca, Nemours, YMCA, and the Mental Health Association and identified an adolescent health initiative.

Of the eight Delaware communities having the greatest poverty, one community in each county has been selected to pilot the adolescent health initiative. The expectation is to expand capacity within the next 12 months to the next three communities and then the last two.

The Search Institute has been contracted by the United Way to go to the communities. On December 15, the Search Institute is coming to begin the first full day of training. It will do analysis and assessments of development assets in adolescents in the community and how many assets exist within the community infrastructure.

Youth are recognized as a key component and the United Way has been actively engaging youth in focus groups, an on-going youth council. They will have an equal voice in the process and will develop the campaign, Facebook and Twitter. Research shows that a youth will listen to another youth before they will listen to an adult. It is hoped the older adolescents will reach back and mentor the younger.

Youth are recognized as a key component and the United Way has been actively engaging youth in focus groups, an on-going youth council.

There will be an official community announcement in January 2012 and Ms. Taylor will make the Commission aware of the date when it is determined.

United Way has been working with Nemours to expand community health workers. There is limited funding available and the United Way wants to make certain it is investing in the right strategy and would appreciate any help around that model.

United Way has been working with Nemours to expand community health workers.

Dean Matt commented that the University of Delaware has been looking at the concept of health coaches and health navigators and would be very interested in working with the United Way to look at the need and what are the workforce and education pieces that need to be developed.

Ted Becker added that the changes to CHAP and implementation of the federal Affordable Care Act necessitate the navigator role and believes this is a great opportunity.

Context for Future Commission Meetings

Ms. Riveros provided a framework for issues the Commission will be addressing in the next few meetings. The Commission plays a critical role in the research and policy development in the health care ecosystem in the State of Delaware. Key themes include access to care, system of delivery, the role of technology, utilizing data, prevention and detection, management of chronic disease, workforce development, new payment models and the role of employers to

provide incentives to promote healthy behaviors - these are all inter-related. Today's focus will be the role and value of data in the health care arena and how that data translates into results that has a very real impact on the lives of Delawareans every day.

An Overview of Colorectal Cancer in Delaware - Stephen S. Grubbs, MD (this presentation will be made available on the DHCC website: http://dhss.delaware.gov/dhss/dhcc/presentations.html).

Dr. Grubbs presented compelling data developed from work in screening for colorectal cancer to show on how an effective screening program has translated into savings of lives and even savings of dollars.

Ms. Riveros introduced Dr. Stephen S. Grubbs, Principal Investigator of Delaware Christiana Care Cancer Outreach Program (C.O.P.), Chair of the Early Detection and Prevention Committee of the Delaware Cancer Consortium.

Dr. Grubbs presented compelling data developed from work in screening for colorectal cancer to show on how an effective screening program has translated into savings of lives and even savings of dollars.

In 2002, the Delaware Cancer Consortium was charged with developing plans to impact Delaware's high cancer incidence and mortality rates.

The Consortium opted for a targeted approach, focusing on areas where the impact of intervention could be evaluated and measured in the short term.

The Consortium recommended creating a comprehensive state-wide colorectal cancer screening program and advocacy program. The plan reimbursed for colorectal cancer screening (CRC) of uninsured and underinsured patients in the State. The program worked through Screening for Life and eventually CHAP, and in 2004 universal colorectal screening became available for residents of Delaware.

A case management system was set up for every Delawarean with an abnormal colorectal cancer screening test. A colonoscopy can detect cancer early and save lives, but more importantly, it is a preventive agent by removing polyps.

A case management system was set up for every Delawarean with an abnormal colorectal cancer screening test.

The program provides free cancer treatment to uninsured Delawareans with a household income up to 650 percent of federal poverty level (FPL) for 24 months for anyone diagnosed with any cancer. More than 5,000 screenings have been provided through the program and, to date, more than 1,000 people have received services through the program and more than $38 million has been spent on treatment.

Nurse Navigators where created and charged with recruiting the uninsured to obtain colorectal, breast and cervical cancer screenings.

At least one Screening Nurse Navigator was placed at each Delaware acute care hospital. The Screening Nurse Navigator assists patients in navigating the health care system and overcome barriers to obtaining cancer screening and case manage all abnormal screenings. Over 10,000 people have received navigation services. There is a statewide Cancer Screening Nurse Navigator database to collect detailed screening information on those who have received navigation services.

At least one Screening Nurse Navigator was placed at each Delaware acute care hospital because physicians are hospital centric.

At least one Care Coordinator is at each Delaware hospital and assists cancer patients with care coordination, including social service needs as well as healthcare coordination, so the patient only has to concentrate on treatment.

The Care Coordinators are a statewide network and know each other and work together to ensure patients' needs are met. Initially, the positions were funded by the State until 2011 when budgets cuts discontinued funding, but hospitals picked up the funding.

Data retrieved from screening information indicates that:

In Delaware, in 2010, African Americans were significantly more likely than Caucasians to have had a sigmoidoscopy or colonoscopy within the last 12 months (33.6 percent vs. 23.7 percent, respectively).

From 2002-2010, Delaware's rate of increase in CRC screening prevalence exceeded that of the U.S. for African Americans.

Delaware's CRC screening rate for African Americans increased nearly 57 percent compared to the nation's increase by 49.6 percent.

Between 2002 and 2010, CRC screening prevalence increased significantly in each of Delaware's three counties.

In 2010, 74.0 percent of Delawareans age 50 and older reported ever having had a sigmoidoscopy or colonoscopy. Nationally, the percentage was 65.3. Delaware has the highest screening rate in the United States. Ninety percent is the 'gold standard' - colonoscopy.

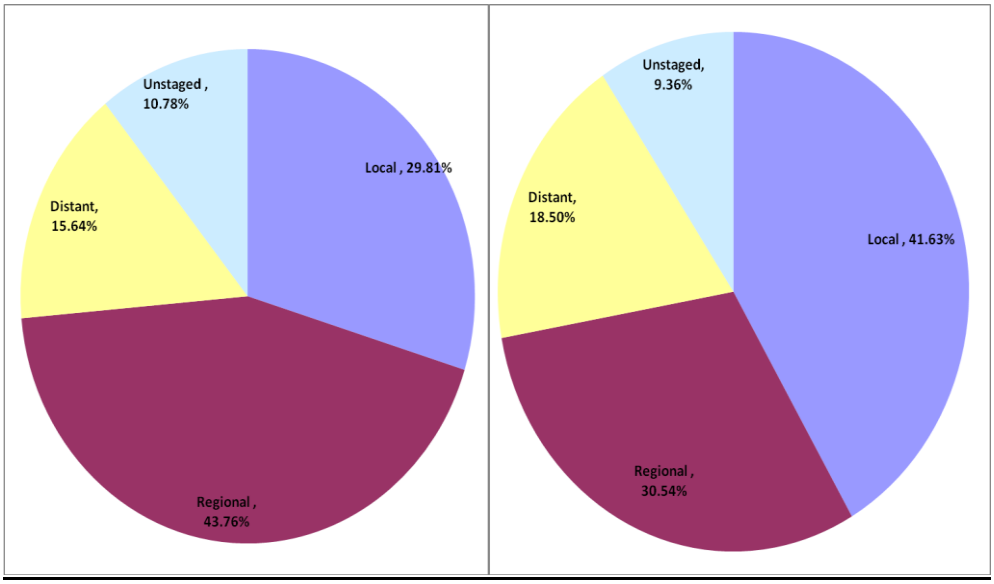
Delaware's CRC screening rate in 2010 for males was 14 percent higher than the U.S. Delaware's female screening rate was 13 percent higher than the U.S.

From 2002-2010, CRC screening rates in Delaware increased 28 percent among Caucasians and 57 percent among African Americans.

In 2010, Delaware's CRC screening rate for Caucasians was 10 percent higher than the U.S. For African Americans, Delaware's rate was 18 percent higher than the U.S.

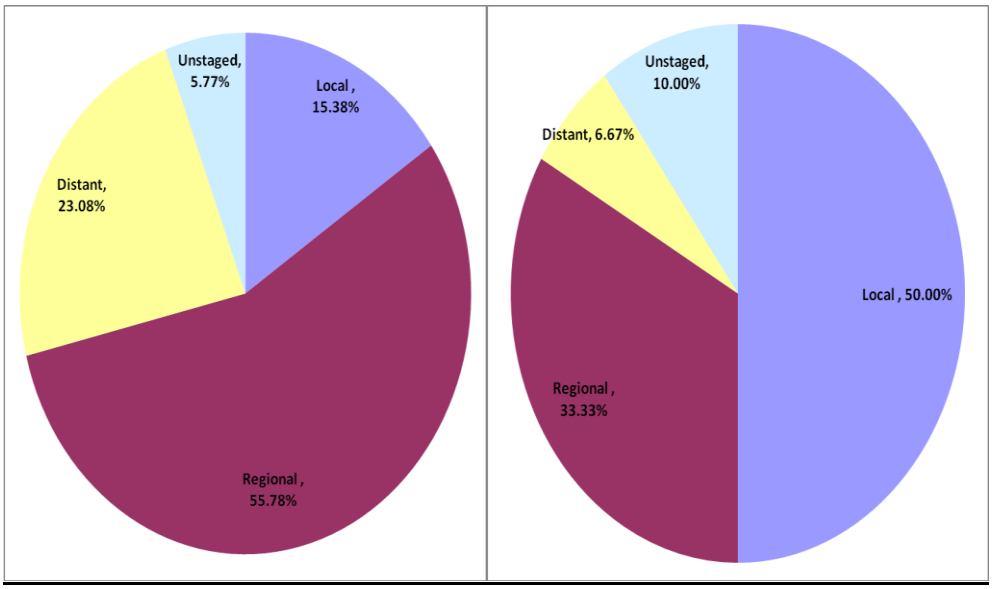
The impact on CRC Incidence and Mortality.

Colorectal cancer by stage of diagnosis, all races in Delaware from 2001-2009



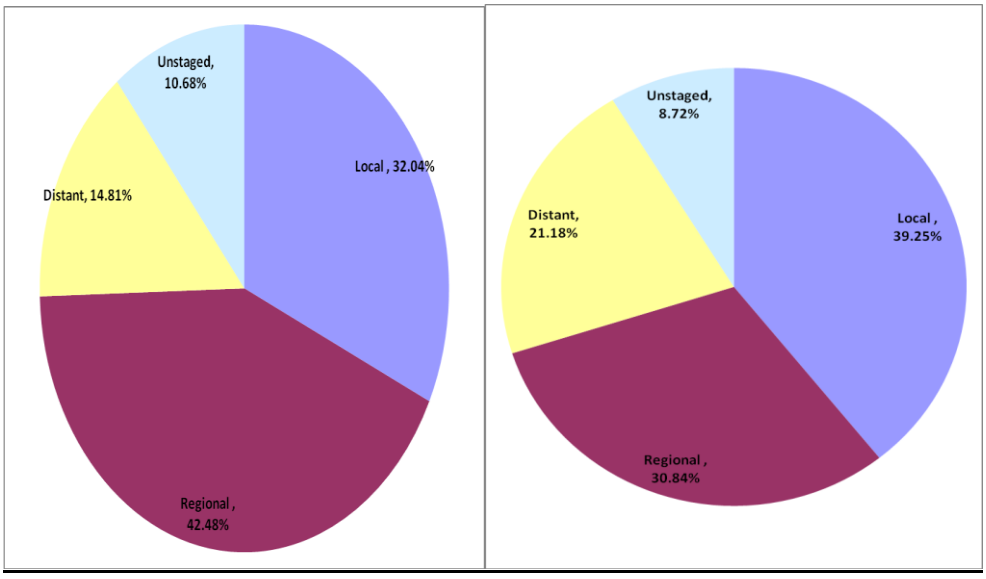
2001 2009

Colorectal Cancer by Stage of Diagnosis, African Americans in Delaware 2001 and 2009



2001 2009

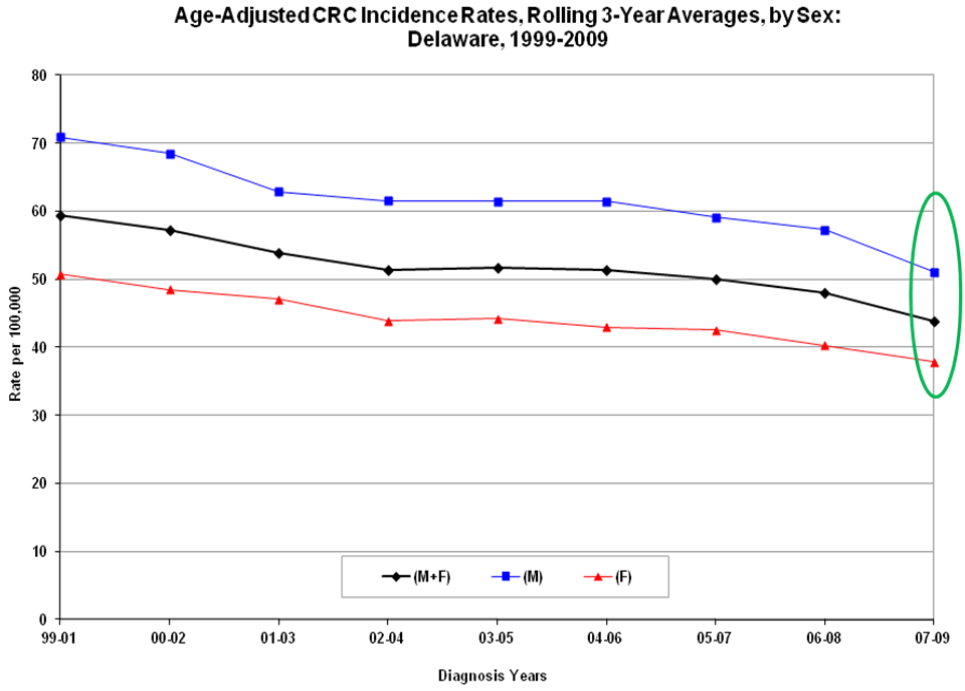
Colorectal Cancer by Stage of Diagnosis, Caucasians, in Delaware 2001 and 2009



Results
Between 2001 and 2009, the percentage of CRC cases diagnosed in the local stage increased by 40 percent.

The magnitude of this increase differed substantially between races: among Caucasians a 23 percent increase in CRC cases diagnosed in local stage. Among African Americans, there was a 225 percent increase in CRC cases diagnosed in local stage.

CRC Incidence: 1999 – 2009 *"Slow, Steady Declines"*



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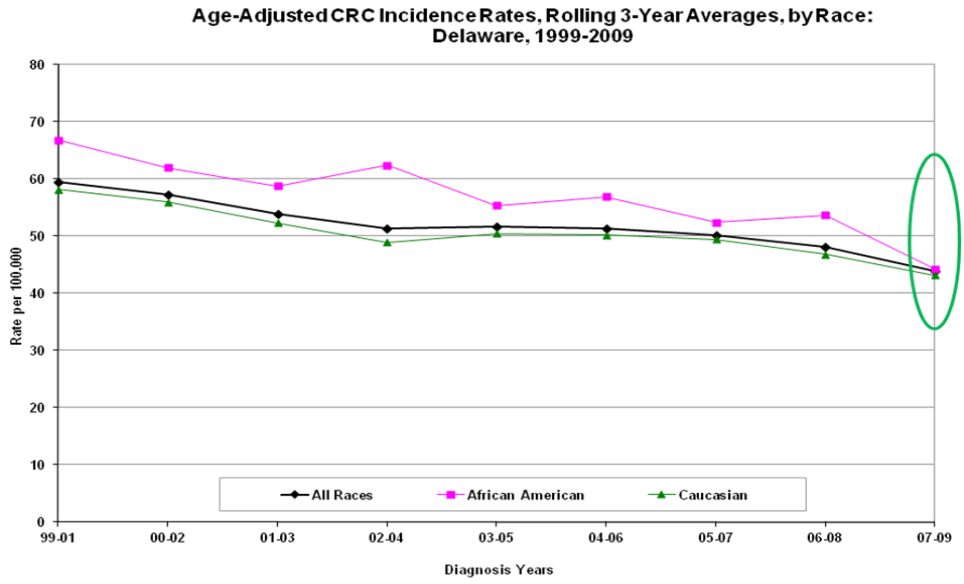
Between 2001 and 2009, the percentage of CRC cases diagnosed in the local stage increased by 40 percent.



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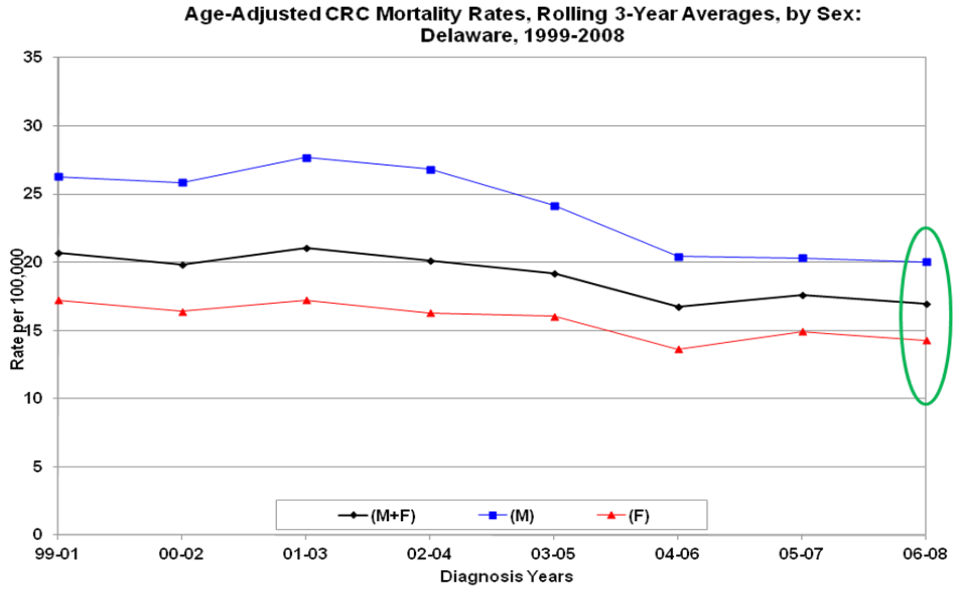
Between 2001 and 2009, the percentage of CRC cases diagnosed in the local stage increased by 40 percent.

CRC Mortality: 1999 – 2008 *"Shrinking Disparities"*



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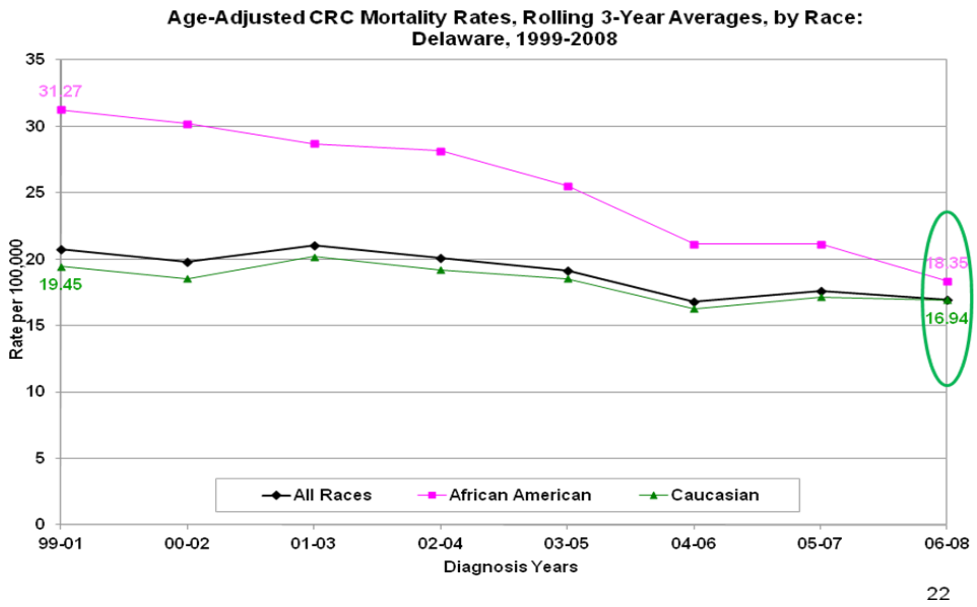

Ms. Riveros asked what the Delaware Cancer Consortium sees as its next steps.

The Consortium's goal is to get the screening rates up to 80 percent.

Dr. Grubbs responded that the Consortium's goal is to get the screening rates up to 80 percent. The challenge is the new data on lung cancer and CT scanning. It is expensive and it is uncertain how to include lung cancer in the program.

Ms. Riveros asked Dr. Grubbs to identify initial key decisions, guidelines or principles that led to the program's success?

Dr. Grubbs said the theory of not being able to do everything at once, '*picking the low hanging fruit*,' confidence that they could put a system together that would work, and choosing a subject where it was known they could make an impact in a very short amount of time. The program has proved with a good use of public dollars, they can have a good outcome on cancer in the State. The project will get bigger and bigger if they have the resources to do it.

Jill Rogers of the Division of Public Health added that it adheres to the standard of quality of care. She served on the Disparities Committee and remembered having many discussions around how they should screen, and that people wouldn't have access on colonoscopies. Dr. Grubbs held to the gold standard of having a colonoscopy.

Dr. Petrelli said 94 percent of individuals who have gone through screening in the State have gone through colonoscopy.

Dean Matt congratulated Dr. Grubbs on the incredible study. The study is a good example of the science, and its translation into impact on people and populations. Clearly, there was a goal in mind with this based on the science and based on the desired outcomes. She asked if there is a template that could be created from this with best principles and guidelines that would help with taking a similar approach but roll out into other areas like obesity and cardio-vascular disease. Dean Matt was impressed with the better outcomes and dollar savings and noted that all researchers try to reach these findings. She asked what lessons could be learned from this experience.

Dr. Grubbs answered that a template could be created from this but the key was the people around the table. It was the dedication of the multi-specialties of the people serving on the Consortium. He credited Consortium Chair, Bill Bowser with his political knowledge. In addition there was expertise from physicians, experts from the Division of Public Health, the Nursing Association, the University of Delaware and people from the community. Everybody bought into the project and had the energy to make it go forward, and the government supported the project, and then the hospitals supported project. He noted that the people who started this program are still working on it.

Discussion

Jonathan Kirch of the American Heart Association of the Delaware Chapter said that Dr. William Weintraub, Chair of Cardiology and Director of Christiana Care Center for Outcomes Research, a national expert on comparative effectiveness, published a policy paper in the journal "Circulation" titled, '*The Value of Prevention.*' It spells out a similar approach for cardio-vascular disease and obesity. Mr. Kirch offered to e-mail the paper to the Commission. It will be made available to the public on the DHCC website: http://dhss.delaware.gov/dhss/dhcc/presentations.html

The Consortium's goal is to get the screening rates up to 80 percent.

94 percent of individuals who have gone through screening in the State have gone through colonoscopy.

Dr. Grubbs said that every physician in the State who can perform a colonoscopy, not just the gastroenterologists, is on board with the program. Program representatives went to each hospital site and recruited physicians. There was no issue with it - they are paid Medicaid rates for screenings. Primary care physicians and nurse practitioners with patients needing colonoscopies can contact a Nurse Navigator who will take care of everything.

DHSS Secretary Rita Landgraf noted that Dr. Grubbs has always been very, very gracious about extending the credit to everyone else and excluding himself. She wanted him to know how much his passion is appreciated.

Secretary Landgraf thanked Dr. Grubbs for his leadership in the program.

Dr. Grubbs was asked about lung cancer screenings, and he said that is going to be the next project in the next 12 to 24 months. A study was published last July on heavy smokers wherein chest CT scans were done for three years, detect cancer earlier and has an outcome of less mortality. He asked the people doing the study what happens if there isn't a cancer in three years. There hasn't been a cost analysis but one is underway. That whole screening issue is up in the air. It is being looked at nationally and it will have to be addressed in Delaware. Part of the Committee's job is to set the standards for screening for cancer in Delaware. The standards set for the State vary slightly from some of the national standards because the Consortium analyzes data on screenings and develop recommendations on how to screen for Delaware.

Lung cancer screenings are going to be the next project in the next 12 to 24 months.

Pancreatic cancer has moved to number four in the total death rate in the United States, ahead of prostate cancer. There is no good screening for pancreatic cancer and until there a good screening, it is unlikely that a plan can be developed.

All Payer Claims Databases - What Are They and What Could an All Payer Claims Data Base do for Delaware? - Nicholas J. Petrelli, MD, FACS, Bank of America Endowed Medical Director, Helen F. Graham Cancer Center; Professor of Surgery, Thomas Jefferson University

Getting quality outcomes has to do with getting quality data. Without quality data, improved outcomes remain elusive. Think of it as strengthening the health care database infrastructure that we now have.

Databases are created by a State mandate which includes data derived from medical, eligibility, provider, pharmacy and /or dental files from both from private and public payers.

Why create an All Payer Claims Database (APCD) in Delaware? It builds a unified strategy for development and use of health information infrastructure including:

- Claims Data (APCD)
- Clinical Data (DHIN)
- DHIN + APCD = more efficient " Medical Home"
  - Reduce costs.
  - Increase quality of care.

Think about it as an efficiency that will improve the medical home.

Employer Benefits:

- Allow employer coalitions to benchmark cost, preventive service measures & high cost cases across their populations.

- Data used to improve health & wellness programs & engage employers' carriers in joint program development.

Policymaker Benefits:
- Allow estimated & actual impact of policy changes.
- Inform options for payment reform and provider accountability.

Consumer Benefits:
- Provide cost information on specific procedures for specific providers.
- Help patients select high quality, low cost providers.
- Even if consumers do not directly access data, they will benefit as providers improve quality in areas with public quality reports.

Commercial Payer Benefits:
- Provides data for provider contracting negotiations.
- Allows payers to benchmark themselves against their competitors, as well as public programs. (CHIP, Medicaid)

Provider Benefits:
- Allow informed negotiations with payers.
- Ability to have reimbursement data for all types of payers.
- Move beyond analysis of physician performance using Medicare data alone.

Researcher/Public Health Benefits:
- Measure accurate rates of disease prevalence.
- Geographic comparisons to study variations in care among providers.
- Provide first ever source of data about health care delivery in the primary care setting and the majority of the population.

What can APCD Tell Us?
- Quality of Care Data
  - Identify gaps in disease prevention and health promotion services.
  - Evaluate access to care among at-risk populations.
- Cost-Effectiveness Data
  - Assist employers and employees with benefit design and planning.
  - Estimate the cost of potential legislative changes affecting health care.
- Evaluation Data
  - Calculate the actual financial impact of legislation.
  - Evaluate public health interventions.
  - Provide data related to changes in provider practices.
  - Assess the impact of health care reform.

Why is APCD better than what we have now:

- Current health care databases are limited and incapable of "talking" to one another.
  - Medicare & Medicaid: represent a fraction of the population.
  - Hospital Discharge: no treatment data; only inpatient care.
  - Behavioral Risk Factor Surveillance System: no individual-level data; only data for survey items.
  - Delaware Cancer Registry: missing demographic indicators, screening data, etc.

Limitations:
- APCDs capture charges, allowable and payment amounts and patient liabilities from claims data.
- However, carriers reimburse providers outside of claims in several ways:
  - Pay for performance payments.
  - Pharmacy benefit manager rebates.
  - Capitation fees.

- Data on uninsured generally not included but Delaware's FQHC's use electronic medical records (EMR) and we could be the only state with usable data on the uninsured.
- APCDs contain one side of the fiscal health care equation – *expenditures.*
- They don't currently contain on the eligibility files the premium collected at the employee or employer level (states like New Hampshire are using other sources to gather this data).
- Clinical data generally not included, but connection with DHIN can result in more complete clinical, quality, utilization and cost data.

Conclusions:
- APCDs are of great value to policy makers, consumers, employers, carriers, providers as health reform moves forward and transparency requirements increase.
- Without APCDs we will be limited to another "silo" of data that loses great potential as an important piece of our health data management infrastructure.

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Without APCDs we will be limited to another "silo" of data that loses great potential as an important piece of our health data management infrastructure.

Dennis Rochford asked where the database is located and who owns the data.

Dr. Petrelli said to think of the APCD as its 'ability' to talk to the other databases so you are not missing data when it comes to evaluating the quality of care or the cost of care.

Jill Rogers added that different states have different models with how they are set up. Sometimes the database resides with Public Health Department or division and sometimes in the Insurance Department. Different states are exploring different models.

Dr. Petrelli said individuals from different states (New Hampshire and Maine) visited the Consortium to discuss details. APCD will be an evolving process.

Paula Roy said that only a handful of states have state mandated All Payer Claims Databases and they do reside in various agencies. The idea here is to introduce the notion that if Delaware wanted to pursue an APCD it will provide more complete information.

Ms. Riveros said this is a unique moment for Delaware. The Cancer Consortium had the APCD idea as one of its central initiatives for the year. At the same time, there is great progress of the DHIN and a great foundational infrastructure of health information technology in Delaware. Delaware is farther ahead than any state (Vermont is comparable) with the Health Information Exchange capabilities. Delaware is uniquely positioned with this foundation of clinical data it can continue to build upon, with respect to the DHIN. Emergence of the All Payer Claims Databases will deliver value. There will also be some intersection with the Health Insurance Exchange.

Dr. Grubbs said 17 states are utilizing the APCD at this time and numerous states are in the planning process.

There are 17 states that are utilizing the APCD at this time and numerous states are in the process.

Ms. Roy said 17 states have legislative mandates for APCD but there are voluntary activities going on in many other states.

Ms. Riveros has invited Dr. Jan Lee, the Executive Director of the DHIN, to one of the upcoming Commission meetings to provide an update on the DHIN.

Dr. Petrelli said when he arrived in Delaware in 2001 the State was number one for cancer incidence and mortality in the United States. The American Cancer Society projects Delaware will be number 12 for cancer mortality. Two years ago Delaware was number 11. Delaware is out of the top 10 list for cancer mortality in this country. The cancer mortality rate in Delaware is dropping twice as fast as the U.S. rate. That is really due to the force behind the Delaware Cancer Consortium, and the collaborative effort that is unprecedented across this country.

The cancer mortality rate in Delaware is dropping twice as fast as the U.S. rate

Dean Matt thanked Dr. Nicholas Petrelli for his work in the development of the Helen Graham Cancer Center.

Dr. Petrelli was asked about the time frame for completing an APCD. He responded that it is an evolving process.

Jill Rogers agreed and said there is a certain amount of urgency if an APCD is to be used to evaluate the impact the Health Care Reform. Getting something usable in place in advance of 2014 is going to

give Delaware much better information about what is happening now and what happens as a result of implementation of the Affordable Care Act in 2014. The sooner Delaware is able to implement an APCD and have usable information a better before and after comparison can be done.

Ms. Roy suggested a careful step by step process produces better results in the long term.

Ms. Riveros agreed and noted the need to start with the end in mind and indentify reports you want and information you want to have at the end. Nonetheless, it is important to proceed quickly.

CHAP and Screening For Life Integration- Update - Jill Rogers, DHSS, Division of Public Health

The budget for CHAP was significantly reduced by a little more than $400,000.00 between FY 11 and FY12.

- The enrollment process is integrated
- Work is continuing on IT, which is always a little bit lagging behind.
- The total CHAP enrollment July 1 equals 9,555.
- New CHAP enrollees are 1,482
- Of those, 547 were not previously enrolled in Screening For Life (SFL).
- Sixty-nine of the new enrollees had expired enrollment in SFL and were re-enrolled.
- Over 140 people have been referred to the diabetes self management program.
- Smokers are routinely referred to the smoking cessation program.
- Women of child-bearing age are automatically enrolled in Healthy Women-Healthy Babies program.

Over the next few months, Public Health is going to make sure these people actually get screened.

Secretary Landgraf said there is a lot of work to do relative to infant mortality and low birth weight and by combining CHAP and SFL and navigating the women of child bearing age into the Healthy Women-Healthy Babies program is really beneficial because that is the area where Delaware is really lagging behind the rest of the nation.

Patient Centered Medical Home Update

Dr. Janice Nevin, Ms. Roy and Ms. Riveros are working together and created a draft workgroup and are reviewing various models. Dr. Nevin is calling it the *Advance Primary Care Practice*. There are plans to invite a speaker who has been evaluating models on medical homes around the country to present to the Commission and expect to have that meeting later this month or early next month, depending upon her availability.

r. Janice Nevin, Ms. Roy and Ms. Riveros are working together and created a draft workgroup and looking at different models of Patient Centered Medical Homes.

Workforce Development
Ms. Riveros and Ms. Roy will be presenting on this topic at next month's Commission meeting, along with assistance from others. Secretary Landgraf and Dean Matt both spoke at a conference at Thomas Jefferson last month. It seems to be critical that the baseline be identified around Delaware's health workforce now. Ms. Roy put together data and information around where the State stands in the workforce and resources available. The Commission can play an important role in making recommendations for the strategy to develop the workforce of tomorrow.

Secretary Landgraf said DHSS had its budget hearing yesterday. Sherman Townsend came to the hearing and did make a statement in support of the DIMER budget. DHSS is making a recommendation to restore the DIMER funding for Jefferson students that was lost in the FY12 budget. Mr. Townsend is asking for additional funding support from a workforce development perspective.

SPECIFIC HEALTH CARE ISSUES

Tier IV Drug Pricing Project

Senate Bill 137 was passed by the Senate and House and signed by the Governor.

(Senate Bill 137 is available on the DHCC website: http://dhss.delaware.gov/dhss/dhcc/presentations.html).

Senate Bill 137 was passed in the most recent session of the General Assembly and specifically asked the Delaware Health Care Commission to conduct a study for specialty tier prescription drugs to determine impact on patient care and submit a report on its findings by March 15, 2012.

Ms. Roy reviewed Senate Bill 137 that was passed in the most recent session of the General Assembly and specifically asked the Delaware Health Care Commission to conduct a study for specialty tier prescription drugs to determine impact on patient care and submit a report on its findings by March 15, 2012.

Health plans are increasingly using various "tiers" of prescription drugs in their formularies for patient access.

Tier 1 drugs are usually limited to generic drugs, the lowest cost drugs. Tier 2 drugs may have a higher co-pay and are usually comprised of brand name drugs but are on the plan formulary. Tier 3 drugs are the more expensive brand name drugs and have a higher co-pay. Research suggests that Tier 4 specialty drugs started among Medicare plans and is increasingly creeping into the commercial market. These medications are used to treat complex conditions such as multiple sclerosis, cancer, and arthritis.

The Tier 4 medications either have higher co-pays or co-insurance. Co-insurance is a percent of the cost of the drug and is typically higher than a co-pay. The practice of adding the fourth tier and moving them from a co-pay to a co-insurance makes the price of the

drug very expensive for patients.

Participation by members of the Commission will be needed to look at this issue as well as input from patients and advocates, particularly those who are impacted by this new drug price structuring, as well as pharmaceutical drug manufacturers, drug review agencies, pharmacies, and employers.

The group will meet and identify key issues. The group is expected to meet prior to the holidays to begin a discussion, and again in January and February, present a report to the Commission in March for some final recommendations so a report can be issued to the General Assembly by March 15.

Ms. Riveros pointed out that at the October Commission meeting, Dr. Nevin suggested a medical ethicist be included is the discussions. She and Ms. Roy worked on a list of representatives from different constituencies to make sure that everyone is well represented.

A public observer asked how anyone interested in participating in the discussions could become a member of the Committee. Ms. Roy said to contact the Commission office and staff will let people know when the meetings are scheduled. These meetings will be open to the public.

A member of the public suggested as work is going on at the federal level to develop the essential benefits offered through the Exchange that the workgroup take into consideration the work being done on that level so that there is some coordination of efforts.

Ms. Roy agreed and said there are two reasons why the federal Centers for Medicare and Medicaid Services should be involved in the discussions; 1.) to understand what gave rise to this in Medicare and 2.) that we do crosswalk with the Essential Health Benefits.

Ms. Riveros believes that CMS is expected to publish the rule in early January, followed by a comment period for the Essential Benefits package. The Institute of Medicine (IOM) recommendation offers some view of what may be included.

Cheryl Heiks asked if somebody from the State will be included in the discussions because the State is a self-insured large employer. Ms. Riveros responded that a representative from the State Employee Benefits Office would be on each of these workgroups. At this point there is no Tier 4 among State employee benefits.

Ms. Heiks said that some of this came about because of the pending situation between Highmark and Blue Cross. Highmark's policies are a little different from Blue Cross and asked if anyone from the

Insurance Commissioner's office will be included.

Ms. Roy said inviting the insurance industry was discussed and Ms. Riveros added it was a good suggestion to invite someone from the Department of Insurance.

OTHER BUSINESS

Sunset Review - Update - Paula Roy

The Health Care Commission was selected for Sunset Review next year by the Joint Sunset Committee.

The Health Care Commission was selected for Sunset Review next year by the Joint Sunset Committee. A draft of the Sunset Review questionnaire was provided to Commissioners in their November meeting materials.

The Sunset Committee hired staff to fill its vacancy in late October. Because the Sunset Committee was late hiring staff and because the Commission did not meet until today, the due date to submit the response to the Sunset questionnaire was extended until November 14. Commission staff is interested in comments from Commissioners on the questionnaire. Ms. Roy noted that is will be more critical for the Commission to be involved during the public hearing portion of the review which will be in the beginning of 2012. If Commissioners have thoughts on the questionnaire, please submit them to Commission staff.

The process begins with the questionnaire. Sunset staff will write a report for the consumption of the Joint Sunset Committee. From there, there might be questions and recommendations. Staff and the Commission will have opportunities to review the Sunset staff report prior to it being released to the Sunset Committee. There will be an opportunities for additional input.

Medical Licensure - Update - Paula Roy

At the October Commission meeting, comment was made that it seems to be taking more and more time for physicians to become licensed. The Commission asked staff to find out more information about that.

The average process for physicians to be licensed in Delaware takes 96 days this year, a drop from 109 days last year.

Ms. Roy said the Division of Professional Regulation reports that on average, the licensure process has dropped this year from last year. The average process for physicians to be licensed in Delaware takes 96 days this year, a drop from 109 days last year. The average licensure process for physician's assistants this year is 43 days, a drop from 55 days last year. There are several things that can cause that process to go longer than 96 days. As brought up in discussion at last month's Commission meeting, speculation that a series of bills that were enacted in the General Assembly last year in response to the tragic situation with Dr. Bradley has put more steps in the licensure process and has required the submission of more documentation, that can take a longer time.

On the Division of Professional Regulation website there is a checklist for applicants and all the forms that need to be submitted. It is a complex process and it is very comprehensive. Applicants have to request a State and federal criminal background check that includes arranging to be fingerprinted. Once the application has been submitted, the Division reports that one step can take up to 3 weeks to complete.

Previously, applicants were required to submit a service letter from where they last worked. Now applicants have to provide a service letter from each health care facility where they are currently are or have worked for the past five years -either direct patient access, admitting or staff privileges. If someone has been licensed in multiple states, that process of gathering all of those letters and encouraging a former employer to submit that letter can take some time.

There is a new disclosures section that asks for extensive information on any criminal offense, any penalty, conviction of fraud, any denial or revocation of a medical license, any discipline by hospital staff, medical society or licensing board, any denial or restriction on privileges by a hospital, a health facility, an HMO or health system or any malpractice claim ever filed. Filing a claim does not necessarily mean that malpractice has occurred but that information and any willful violation of confidence of a patient must be disclosed.

There is a physician self-report form that is included in the application process. If that form does not cover whatever situation the physician has to report, the applicant has to file a separate report and have it notarized.

There is a new Delaware Child Protection Registry Request Form which must be submitted to the Department of Services for Children, Youth and their Families. The website says to allow 15 working days for those results to be processed.

Applicants must also request a self-query from the National Practitioner Data Bank, where any event is reported. Once that report is issued, it is mailed to the applicant who must mail it to Division of Professional Regulation. Staff of the Division of Professional Regulation verifies the information on the data bank. If information is missing, they have to go back to the applicant to resolve the inconsistency.

Delaware's physician licensure application process is very much on par with Maryland, Pennsylvania, New Jersey, Virginia and West Virginia.

Any one of those processes could cause significant delays. After the license is issued, the new physician must submit a new application for Controlled Substance Registration (CSR). The Division of Professional Regulation encourages applicants to apply for a CSR at

the same time they apply for their medical license but some do not. Some wait until they are fully licensed before applying for a CSR. The website says that application processing time can take 3 to 4 weeks. It could be another month before a physician can fully practice.

The final step is a face to face interview with a member of the Medical Board. Generally interviews are match by geographic location. Some Board members conduct interviews using Skype to make that process more efficient.

Ms. Roy was asked how Delaware's physician licensure application process compares to surrounding states and she answered that Delaware is very much on par. In anticipation of that question, the Division of Professional Regulation looked at Maryland, Pennsylvania, New Jersey, Virginia and West Virginia.

Dean Matt observed that while the need to be thorough is understandable, it would be desirable to make the process less cumbersome, particularly in view of the need to recruit physicians to Delaware.

Ms. Roy added that an applicant can log on to the website and track and monitor the progress of their application.

James Collins, the Division Director and Gail McAfee, the Executive Director of the Board or Medical Licensing and Discipline, offered to make themselves available for meetings.

Ms. Riveros said it might be helpful to make sure students understand licensure requirements on the front end so they could prepare as they move through their education and training. It might be helpful for Dean Matt to give some consideration to that.

Connecting James Collins with Dr. Lee, Executive Director of the DHIN, was explored to discuss any role for DHIN around licensing.

Secretary Landgraf's Department has been working on a background check dashboard with Judge Susan C. Del Pesco, Director of the Division of Long Term Care, which integrates with the DHIN, which brings in the drug test results and will be expanded for comprehensive background checks.

Discussion
Brian Olson said Commissioners should be aware that the credentialing process by insurance companies then follows licensing which adds another 2 to 3 months before physicians can start billing and collecting payments.

Mr. Olson announced that in conjunction with the State Office of Primary Care and Rural Health and the Delaware Rural Health Initiative, La Red Health Center will be celebrating National Rural Health Day at the Seaford site on November 17 at 10:00 a.m. It was requested that Governor Markell proclaim that day as Rural Health Day in Delaware.

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The purpose of National Rural Health Day is twofold: 1.) to bring attention to the unique health care needs of rural America. One in five people in the United States live in rural communities. Many of those issues are issues discussed at every Health Care Commission meeting - access to care, workforce development and a disparate number of un- and under-insured individuals in rural America. It is a great place to work and live and it surely tests entrepreneurial spirit. 2.) to showcase the excellent work that is going on in rural communities around health care. La Red Health Center has had a lot of big accomplishments this year: certainly with the implementation of the oral health program, the contract to run Sussex-Kent Wellness Center, federal money to expand the Seaford operation and a creative and unique financing and fund raising effort to construct a

25,000 square foot facility in Georgetown and move the entire operation under one roof. Mr. Olson invited everyone to come and celebrate with them.

Retirement

Ms. Roy announced that after much consideration she has decided to retire from State government at the end of the year and the December Commission meeting will be her last.

Ms. Roy announced that after much consideration she has decided to retire from State government at the end of the year and the December Commission meeting will be her last.

Ms. Riveros said Paula Roy has been a tremendous asset to the State and Commission these many years and will be sorely missed.

PUBLIC COMMENT

Joann Hasse wanted to point out a money issue, medical ethics issue, and a patient issue she learned about by participating in meetings of a transition of care group. Multiple social workers who participate said that when an elderly patient is moved into a nursing care facility, they are asked if they have an Advanced Directive. Family members will often say yes but will not bring it in because they don't plan to honor it. It is like having a will but you don't have to follow it. Apparently this is not uncommon. How can we do anything about it?

Ms. Riveros said Sheila Grant's group is working on standardization of the Advance Directive and the next step is making it part of the patient's medical record. She will follow up with Ms. Grant.

Ms. Landgraf said her effort is largely been for the emergency techs

who come to the house because they are the first responders and prolong life and many times they don't know that (the patient has an Advanced Directive). She has been advocating for that.

Ms. Landgraf said we need a stakeholder group and include the hospitals. Ms. Riveros invited Ms. Hasse to participate in that.

NEXT MEETING

The next meeting of the Delaware Health Care Commission is 9:00 a.m. on December 1, 2011, at the Department of Transportation Administration Building, First Floor, Farmington /Felton Conference Room, 800 Bay Road, Dover.

ADJOURN

The meeting adjourned at 11:15 a.m.

NEXT MEETING
The next meeting of the Delaware Health Care Commission is 9:00 a.m. on December 1, 2011, at the Department of Transportation Administration Building, First Floor, Farmington /Felton Conference Room, 800 Bay Road, Dover.

GUESTS

Janet Bailey	Hewlett Packard
Judy Chaconas	DHSS/DPH
Jim Cannon	Johnson and Johnson
Jeanne Chiquone	American Cancer Society
Barbara DeBastiani	Wheeler and Associates
Tom Ferry	
Dr. JoAnn Fields	Family Practice Physician
Dr. Robert Frelick	Medical Society of Delaware
Joann Hasse	League of Women Voters
Cheryl Heiks	Cozen O'Connor
Hiran Ratnayake	Christiana Care
Emily Kincaid	PPDE
Joan Kirch	American Heart Association/American Stroke Association
Lolita Lopez	Westside Family Health
Matthew Meehan	Pfizer
Jon McDowell	
Mary Norden	Delaware Physicians Care
Sheila Nutter	Hewlett Packard
Brian Olson	La Red Health Center
Rosa Rivera	Henrietta Johnson Medical Center
Jill Rogers	DHSS/Division of Public Health
Christine Schultz	Parkowski, Guerke and Swayze
Paul Silverman	DHSS/Division of Public Health
Michelle Taylor	UWD